



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MAXIM HEALTHCARE SERVICES, INC.

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-13-0378-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: This patient has a letter of agreement to be reimbursed at \$26.00 per hour for service code G0156. Please reprocess these claims for dates of service 12/25/11-3/17/12 and pay an additional \$11,331.54.

Amount in Dispute: \$11,331.54.

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In July 2012 Texas Mutual and the requestor entered into a letter of agreement (LOA) to pay the requestor \$26.00 per hour for home health certified nurse aide services, code G0156. The intent of the LOA was to set the reimbursement for nurse aid services going forward on future dates beginning 7/16/12. The requestor is trying to argue a retro-application is permissible. There is nothing in the LOA that supports that interpretation and the requestor has not been able to provide such support."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 25, 2011 to March 17, 2012	Home Health Services	\$11,331.54	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204(f) sets out the fee guideline for home health services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
 - 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.
 - 426 – REIMBURSED TO FAIR AND REASONABLE.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
 - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
 - 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05
 - 18 – DUPLICATE CLAIM/SERVICE.
 - 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)

Issues

1. Were the medical bills timely filed with the insurance carrier?
2. Are the disputed services subject to a negotiated agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement of the disputed home health services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with reason codes 731 – “PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05” and 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED.” Review of the submitted explanations of benefits finds that the denied dates of service were previously paid by the insurance carrier and the audit date on the EOB supports timely submission of the medical bills. These denial reasons are not supported. Accordingly, these services will be reviewed per applicable division rules and fee guidelines.
2. The requestor submitted a copy of a letter of agreement (LOA) between the health care provider and the insurance carrier contracting for an hourly rate, effective July 16, 2012. The effective date of the LOA is after the dates of service in dispute. The LOA does not specify that the contracted rate is applicable to services performed before the effective date of the agreement. The Division therefore finds that reimbursement for the disputed services is not subject to a contract between the parties. Reimbursement will therefore be determined per applicable Division rules and fee guidelines.
3. This dispute regards health aide and home health services provided by a home health agency. According to the Texas Department of Aging and Disability Services’ Directory for Home and Community Support Services Agencies, the health care provider is a licensed home health agency. Reimbursement for the disputed services is therefore subject to the provisions of 28 Texas Administrative Code §134.204(f) which requires that “to determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.”
4. The Texas Medicaid fee schedule allowance for disputed procedure code G0156 is \$46.09 per visit. 125% of this amount is \$57.61. The submitted medical bills document 74 dates of service, for a total MAR of \$4,263.14. The insurance carrier has paid \$4,350.46. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____ Signature	<u>Grayson Richardson</u> Medical Fee Dispute Resolution Officer	<u>September 2, 2016</u> Date
--------------------	---	----------------------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.